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**Being with as opposed to doing to: a
contribution to mental health research to
transform education and practice**

Thesis submitted in part-fulfilment of the requirements for PhD by published
work

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I would like to thank all the service users, staff and colleagues without whom my contribution to mental health research and practice, and this PhD by published work would not have been possible. Sharing the journeys we have travelled together has been a pleasure and a privilege.

This PhD by published work is dedicated to Diana Constance Bailey, known to her friends and family as Connie, (22nd October 1928 - 7th April 2010).

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PART ONE INTRODUCTION AND THEORETICAL FRAMEWORK

Introduction

My substantial, original contribution to mental health research, education and practice spans 17 years, from the mid 1990s to the present day. It is a journey on which I consider I am still travelling, during which the landscape of mental health services and the workforce that delivers them has changed in an unprecedented fashion. It has been a privilege to have contributed to this metamorphosis which began with my research into diversion schemes for mentally disordered offenders (MDOs) moving onto interdisciplinary mental health education/training and workforce redesign. Latterly, my contribution promoting service user-led research has revisited the care and treatment for MDOs, focusing on the effectiveness of participatory action research (PAR) for effecting improvements in care delivery for individuals with complex mental health needs.

On reflection the distinctiveness of my contribution originates from practice where I have needed to be able to work effectively with other professionals, service users and their families. From my experience as a teaching assistant in a school for children with behavioural difficulties to voluntary work with MIND, as a youth worker and running summer play schemes for children at risk, even before I qualified professionally, I recognised the need to situate my intervention alongside that of others. According to Cohen et al (2007) such personal involvement of the researcher, concerned with understanding actions and meanings from a subjective perspective reflects a practical interest typical of ethnomethodology.

In contrast, my research experience gained during my psychology degree reflected a more positivist paradigm and was concerned with developing an objective measure to evaluate stressful life events for women with breast cancer. Working with large data sets, I reached generalised conclusions about the effectiveness of counselling interventions. Whilst I learned valuable skills in conducting longitudinal research throughout the 3-year study, I found myself more interested in women's collective experiences of trauma, rather than in establishing a scientific measure to capture this life

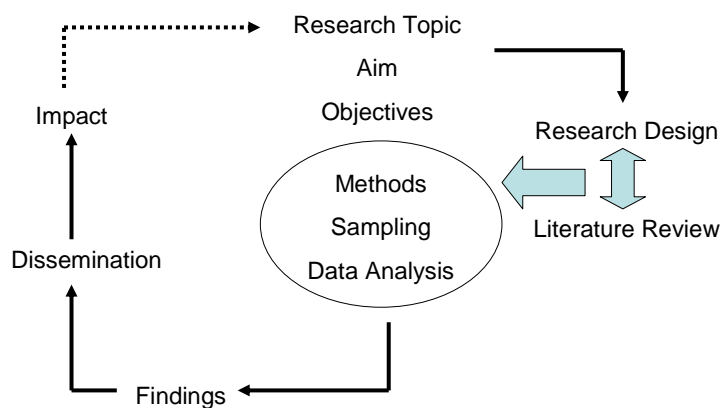
stress. My insights into the opportunities afforded by a mixed methods approach to capture quantitative and qualitative data has influenced my contribution to evaluation research through a model I have developed that draws together elements of outcome evaluation (Kirkpatrick, 1967) and realistic evaluation (Pawson and Tilley, 1997). Researching in this way has allowed me to stay true to my social work values and my commitment to research-informed practice. It is this inquiry-based approach that underpins my overarching research aim, to understand why professionals do or do not collaborate with each other, and with service users and families receiving their interventions.

From the asylum era to the present day, mental health remains a contested field with a legacy of occupational contributions from psychiatrists, psychiatric nurses and clinical psychologists traceable back to the asylum system (Rogers and Pilgrim, 1996). Conversely the social work contribution has its roots in local authority social services' structures, and its theoretical basis in social causation models of mental distress (Brown and Harris, 1978) and social labelling theory (Scheff, 1966). With the demise of the asylum and the shift towards community mental health teams, and latterly specialist mental health services (Department of Health Policy Implementation Guide, 2001), a fundamental objective of my research has been to evidence why interdisciplinary working is delivered more effectively in some mental health settings than others including the impact this has on service users and staff.

Throughout this PhD by published work I attempt to demonstrate my application of research as a process, alongside the significance of my findings (see Figure 1 below). My research aims and objectives are underpinned by the use of mixed methods to capture debates from my interrelated disciplines of social work and mental health. As evidence of how I have applied research methods I go on to consider how I have taken the debates about what constitutes effective mental health, recovery and service user involvement into settings where the needs of service users are more complex and the models of care delivery required more challenging to provide.

I also demonstrate my understanding and application of research methods in the way I have designed the research studies I have conducted, then interpreted and disseminated their findings. My thesis seeks to integrate what I have contributed in ways that are characteristic of a highly, experienced and effective researcher, as set out by the Economic and Social Research Council in 2009.

Figure 1: Research Process



Theoretical Framework and Philosophy of Approach

My philosophical approach to understanding interdisciplinary working and learning in mental health has been informed by my immersion in mental health services throughout my career. Hammersley and Atkinson (1995) consider that such participation and reflexivity of the researcher, watching and listening to what happens and is said contributes an indepth understanding of people's lived experience in their naturalistic settings.

Through my research I continually revisit that which I do that has become part of my unconscious competent self. My insight leads me to conclude that in all the research I have undertaken I have attempted to strike a balance between ensuring that the participants and stakeholders feel motivated and engaged to take part and that they are cared for whilst the

research aims and objectives are fulfilled. In this respect I consider I have contributed research leadership to the field of interdisciplinary mental health care. Through the ways in which I have designed, delivered and disseminated research, I have focused on teams, individuals and the tasks they need to undertake, modelling a transformational leadership approach as illustrated by Adair (2003) and McNichol and Hamer (2006). This has allowed me to conduct research that stays true to my social work values that set out to empower and include a 'being with' rather than 'doing to approach'. This philosophy has been the thrust of my book on interdisciplinary working in mental health (Bailey, 2012, [1]¹).

During periods of organisational change and upheaval, as has characterised the shift to interdisciplinary mental health care since the 1980s (Walker, 2013), human beings need a sense of: direction, belonging and identity if they are to collaborate to improve care outcomes. Through my research I have offered this approach in original ways, to the range of stakeholders with whom I have collaborated (see Figure 2 below). Through researching and theorising training and evaluation within the mental health workforce (Theme A) I have influenced the direction of service development, professional training, and service user involvement in mental health services from the naissance of the National Service Framework (NSF) in mental health in the mid 1990s to the present, with the inquiry into the future of mental health services (Bailey and Ryan 2013) [1, 2, 7, 14-16, 19-27].

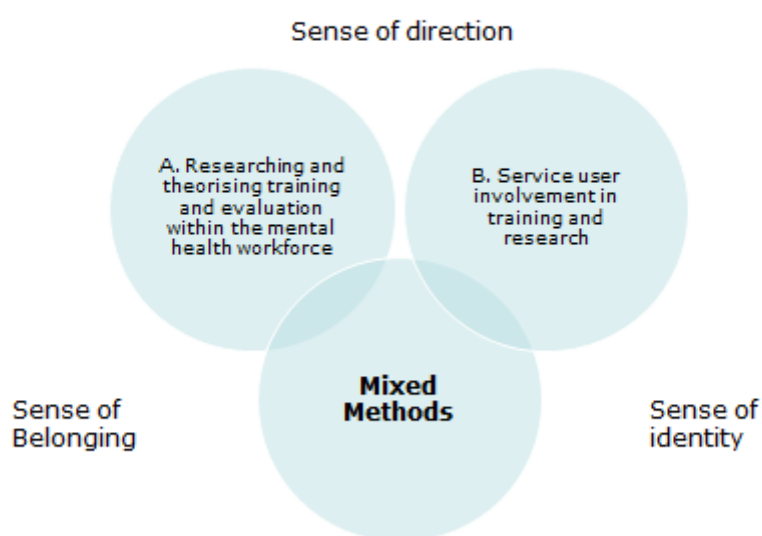
While there is a tendency in mental health research to understand the challenges of interdisciplinary working from a team, organisational or policy perspective (Onyett, 2003) literature is less focused on how personal problems of individuals and families reflect these wider service contexts. Understanding how the personal is the political permeates social work (Thompson, 2009). My research with service users with complex interrelated mental health needs (including substance misuse issues, self-injurious behaviour and offending) has sought to involve them in the co-

¹ My book on interdisciplinary working parts 1 and 2 (Bailey, 2012 [1]) expand upon Themes A and B of this PhD by published work. Chapters 6 and 10 relate to Theme B.

production of knowledge about what works in mental health care and recovery to groups experiencing multiple, intersecting disadvantage (Theme B) [1, 4, 5, 6, 8-13, 17-18, 26-27].

Both these themes demonstrate my commitment to an approach that includes the lived experience of services users and their families alongside that of professionals and has allowed me to influence change and improvement with the whole range of stakeholders. Researching in this way has led me to re-define interdisciplinary working in mental health (Bailey, 2012 [1]) and taken me into the territory of anti-oppressive methods that reflect the value base of my social work training. Through the use of PAR in particular, I have been able to explore the consequences of giving power away to service users and practitioners to support improvements in mental health care [1, 4, 5, 9-10, 12-13, 17, 25].

Figure 2: Contributions of my PhD to the Change Agenda in Mental Health



Part 2 of my thesis will explore the two themes highlighted above interconnecting through the methods employed, demonstrating how my substantial and original contribution has embodied the research process set out in Figure 1. Part 3 will conclude with my reflections on my journey thus far and how this will inform my continuing contribution.

PART TWO: RESEARCH THEMES

A. Researching and Theorising Training and Evaluation within the Mental Health Workforce

Opportunities for interdisciplinary working begin when an individual makes contact with mental health services, and continues throughout their care journey. My first experience of research as an academic focused upon this initial contact in the form of diversion schemes for mentally disordered offenders. During the 1980s politicians became increasingly interested in the ways in which mentally disordered offenders (MDOs) were dealt with by the criminal justice system. Despite policy developments such as the Health of the Nation (DH, 1993), the Care Programme Approach (1991) and the Home Office Circular 66/90 there was little clarity about how to work effectively with this group of service users. Where diversion schemes had been established (Staite et al, 1994) they aimed to address professionals' needs for better collaboration rather than the needs of the MDOs per se.

The research study was commissioned by one local authority to explore opportunities for integrated working between the police and mental health professionals at the organisational level, addressing the gap that existed in the research (Bailey, 1996 [29]). Having undertaken a review of the literature on diversion schemes in preparation for the fieldwork stage, I found myself leading the remainder of the study on account of the unexpected departure of the Principal Investigator. To understand the strategic barriers to and support for improved coordination of services between the police, mental health Trusts, and social services departments, my contribution included designing and undertaking in-depth interviews with senior police officers and mental health managers responsible for developing local diversion policies. In accordance with a purposive sampling strategy, I interviewed police officers, mental health practitioners and service user groups involved with implementing diversion initiatives.

In addition I analysed quantitative data relating to the use of section 136 of the Mental Health Act 1983 using simple statistics to show trends in

outcomes from diversion at point of arrest. This gave an indication of how the policies were working in practice, in terms of the place of safety used, the timeliness of an ensuing mental health assessment, or the redirection of MDOs back into the criminal justice system. I produced a final report, and shorter executive summaries that were disseminated to the range of stakeholders in a county wide event. My research findings resulted in a redistribution of power reflected in a significant policy change. Senior managers acting on my findings, took a strategic decision that region-wide the place of safety used in the diversion process would switch from police stations to bespoke provision provided by the voluntary sector. This shift reflected senior managers' concerns, reinforced by those of service users and staff, about the tension between a police cell as a place of containment and as a setting for care and prevention. I return to this tension in the care of MDOs in my subsequent research set out in Section B (Ward and Bailey, 2013b, & 2012 [5, & 9]).

With the introduction of the National Health Service and Community Care Act (NHS & CCA) in 1990 and the Care Programme Approach (CPA) in 1991 policy makers left no doubt about the need for a greater integration of mental health services in order to address the holistic needs of service users (DH, 1995 and 1998a). Key to this agenda was improved co-ordination between hospital and community care with primary care services (principally GPs and practice nurses), occupying a pivotal position in the care pathway (DH, 1999b).

By the late 1990s important reports published by the Sainsbury Centre for Mental Health (SCMH) together with the launch of the National Service Framework for Mental Health (DH, 1999a) highlighted the training issues associated with this service development agenda notably:

- communication and team working needed to transcend referral procedures between primary care and community mental health teams
- core skills shared across different professional groups were more important than the discipline-specific skills which differentiated them (Duggan, 1997) and

- the quality of care provided by acute in-patient staff was beleaguered by a substantial skill deficit (SCMH, 1998)

Working with Duggan and colleagues at the SCMH, as Chair of the then Quality Assurance Network in Mental Health, I tried to facilitate ways in which mental health education and training could be developed to support the Pulling Together agenda, in particular power sharing between professionals delivering care and service users and their carers who were receiving it. In a consultancy role with the local authority and mental health Trusts in Birmingham I led the development of joint documentation for the CPA and supported this with associated training to promote better coordination between hospital and community services. As a participant observer of these 'coming together' processes I began to formulate a model of mental health care where the bricks of the Victorian institutions held together by the 'mortar' of uniprofessional working were transcended by paperwork that promoted a process of participation. As practitioners and service users struggled to make sense of the shift, their struggle reflected a strategic battle for power and influence over mental health service delivery between health and social care providers (DH, 1998b & 2000).

Several 'continuum' models have described this shift towards greater partnership working (Arnstein, 1969, Hickey and Kipping, 1998 and Peck et al 2002). Through my contribution to help mental health practitioners and service users make sense of this emerging partnership agenda for change I solicited chapters from colleagues for a text book focusing on the 'core' of contemporary mental health practice, with the explicit aim of informing education and training curricula (Bailey, 2010 [2]). My contribution was to develop and synthesise my ideas about the CPA as a process (Bailey, 1997 [28]) that could integrate hospital intervention at times of crisis with discharge planning and ongoing care management in the community. My conceptual approach was original as since the introduction of the CPA in 1991 its effective implementation had been thwarted by its use primarily as a discharge planning tool, rather than as an overarching care coordination framework, linked with the mental health legislation.

In *At the Core of Mental Health* (Bailey, 2010 [2]), I set out to make the CPA more accessible to staff as a mechanism for supporting better interdisciplinary working to bridge hospital, primary and community care, a standpoint later reinforced by government policy (DH 2008, a & b). This revised policy guidance allowed me to enhance my theory in the chapter updating the CPA in my recent book on interdisciplinary working in mental health (Bailey, 2012 [1]). In this chapter I advocate interdisciplinary care planning as an opportunity to support a recovery focus in care delivery highlighting the CPA's continued applicability more than a decade since its introduction and despite subsequent changes to mental health policy and the overarching legislation (Mental Health Act 2007). This original, theoretical perspective allows me to redefine interdisciplinary working as that which acknowledges service users as active participants in their care, sharing power with professionals in the co-production of knowledge about what works for effective recovery.

The political emphasis on integrated working in mental health was reinforced with the introduction of the National Service Framework (NSF) in 1999 with standards aimed at supporting the greater involvement of service users and their families in service development, education and training. The practicalities of power sharing for achieving such involvement I had already started to write about (Bailey, 1998 & 1997 [26 & 27]) thus placing me in a position to respond to calls from the policy makers to undertake research on the contribution of education and training to the NSF agenda for change.

In 1999 I collaborated with colleagues from the Sainsbury Centre for Mental Health (SCMH), funded by the Department of Health (DH), to research the extent to which current mental health training in England would equip qualifying practitioners to deliver the NSF standards (Brooker et al 2002 [23]). Drawing on my previous involvement with service user groups, I undertook focus group discussions together with documentary analysis to map data from individual course curricula to agreed indicators of involvement. This meant that the findings from the study were able to offer for the first time, a national illustration of the extent to which mental health courses involved service users in their design, delivery and evaluation.

This mapping exercise identified significant, regional variations in training design and delivery and the increasing need for psychosocial interventions training in mental health at post-graduate level, if the NSF standards and workforce change agenda was to be realised.

By this time, I was leading such a programme at Birmingham University, the MA in Community Mental Health known as the RECOVER programme. Throughout its inception and design I had modelled interdisciplinary working in the way I had developed its curriculum with colleagues from psychology, nursing and psychiatry, contributing my own social work experience and including contributions from service users. This was the first programme in the UK to equip practitioners with skills in evidence-based treatments including psychosocial interventions underpinned by a person-centred value base. The programme was geared specifically to foster professionals' capabilities to work collaboratively with different disciplinary groups including service users and carers.

Using an outcome evaluation framework (Barr, 1996) The RECOVER programme was the first to be evaluated longitudinally over a 5-year period. Carpenter et al (2003) used validated measures to assess team working, and service users' quality of life of (Oliver et al, 1991) to build on previous smaller scale, evaluations that had compared shared learning for just two professional groups (Carpenter and Hewstone, 1996).

Findings emerging from the 5-year longitudinal evaluation (Barnes et al, 2000 [25], Bailey and Littlechild (2001) [24]) testified to the effectiveness of the interdisciplinary approach and led me to undertake commissioned research through which I extended the outcome evaluation framework to include elements of realistic evaluation (Pawson and Tilley, 1997) to investigate further the fit between post qualifying mental health training for workers in primary and specialist mental health services, and a workforce that could meet the demands of the NSF (Bailey et al 2003).

The development and use of this evaluation framework has been pivotal in my work, in terms of both research and practice. The combination of research methods I employed in this latter study positioned centrally my contribution within the body of process evaluation research and demonstrated originality by combining a shorter and academically rigorous systematic review process, tailored to a review of qualitative studies, with a multi-level evaluation framework that expanded on outcome evaluation frameworks used previously (Barr et al 2000, Kirkpatrick ,1967 and Warr et al, 1970). This approach to evaluation has offered a single and comprehensive framework that ensures the analysis of contextual factors and training inputs in addition to multi-level outcomes such as changes in practice. This approach allows for a better understanding of how process and outcomes interrelate and I will offer several examples of where I have embedded and sustained my original approach in subsequent sections.

I have continued to refine the use of mixed methods through other research projects where I have combined interpretive and critical approaches to understanding interdisciplinary working in mental health (Bailey and Kerlin, 2012 [6], De Motte and Bailey, 2012 [8] and Ward et al 2012 [10]). According to Merton and Kendall (1986) combining methods allows the researcher to use the most valuable features of each, though the problem comes in determining at which point to adopt one or the other. Three examples of how I have responded to this dilemma follow, illustrating my research skills in using mixed methods and triangulating data.

Example 1: Interdisciplinary Working with Dual Diagnosis

Research testifies that service users with mental health and substance misuse needs do poorly on a number of outcomes, primarily as a result of services being offered sequentially or in parallel rather than in an integrated way (Watkins, 1997, Keene, 2001, DH, 2002). Having undertaken a systematic review of the literature to explore existing screening tools for dual diagnosis in order to inform training course curricula, I set about trying to identify a common skill set for both mental health and substance misuse workers which I could then evaluate using the multi-level evaluation framework I had developed previously (Bailey, 2002a [21]). My initial

findings extended existing research by evidencing that interdisciplinary working was compounded by the different language services used to describe the same service users (Bailey, 2002a [21]). This in turn perpetuated power struggles between professionals and service users and between services reflected in service eligibility criteria that hinged upon different assumptions drugs and mental health workers made about service users' motivation for change, which often led to an impasse and neither service assessing risk.

Using a purposely designed tool, informed by my initial findings and piloted with 30 drugs and mental health workers, I embarked upon a longitudinal evaluation over a 24 month period during which four cohorts, totalling 92 workers, experienced a training intervention to encourage collaborative working (Bailey, 2002b [22]).

Methods in this phase of my research included a content analysis of the course curriculum using a recognised typology developed by Barr (1996 & 2002). Self-report measures that I had developed during the pilot phase, measured workers' reactions to the training and how they intended to apply their learning in practice. A questionnaire completed at T1 before the training and at T2 one month following, captured data from one cohort, pertaining to up to 4 service users with dual diagnosis as to whether a joint risk assessment had been undertaken by mental health and drugs workers. Also whether interventions more generally were being provided separately by drugs and mental health services or whether, following the training more collaborative working was taking place.

The longitudinal aspect of the study (T2 follow up) I introduced so that I could capture the contextual factors workers experienced in their work setting, that could help explain the power dynamics affecting interdisciplinary working and why in the area of risk assessment, planning and management with this client group interdisciplinary working was so difficult to sustain.

My data analysis included statistical tests to establish whether significantly more joint interventions were provided at T2. My findings showed this not to be the case, primarily because mental health workers were providing the majority of interventions and almost a quarter of the service users identified at T1 (n=44) were no longer in receipt of services at T2 (n=33), either because they had been discharged from hospital, moved out of the area or just lost contact. My findings did demonstrate, however, that once practitioners gained increased knowledge about the different policy and legal frameworks used in each service and could understand the language of their colleagues in respect of the CPA and risk assessment, barriers to interdisciplinary working were lessened and coordinated care improved. Also practitioners in both mental health and drugs services felt more confident and competent to make effective decisions in respect of risk assessment and management for service users with complex needs and that these decisions mitigated against a continuing fragmented approach to care delivery.

The impact of new knowledge from my research was that it informed integrated care pathways for service users with dual diagnosis in several mental health Trusts in the West Midlands and assisted with the mainstreaming agenda for this client group introduced by the DH in 2002.

Example 2: New Ways of Working in Mental Health

By the mid 2000s the New Ways of Working (NWW) agenda in mental health had gathered momentum in a further policy drive to cement the NSF (DH, 2003, 2005a and 2007). Increasingly, highly qualified professionals were being required to work differently while a number of new roles for affiliated staff including Support, Time and Recovery (STaR) Workers and graduate primary care mental health workers, were being introduced into the mental health workforce (DH, 2007). The influence of these changes reflected a need to relinquish traditional professional power bases which, I explore in (Bailey, 2012 [1]) in my evolutionary account of interdisciplinary working.

Having extended evaluation research to the first training programme in the UK for graduate primary care mental health workers (Bailey 2007, a & b [15, 16]) I was commissioned to collaborate with colleagues at Newcastle University to undertake an extensive evaluation of the raft of new roles nationally. Reinforcing earlier work (Bailey, 1998 and 2005) I influenced the design of the research study to promote greater service user involvement in the research process by including a role for service users and carers as participant researchers, developing their awareness and understanding of NWW. The research consisted of two stages with Stage 1 focusing on discipline-specific roles (for example trainee psychologists) that had already been piloted in some mental health Trusts.

Stage 2 involved a multi-case study design, in 8 national sites, representative of the new roles and ways and working. Qualitative data collected in these sites came from in-depth interviews and focus groups. As findings emerged from stages 1 and 2 service users and carers would come together to consider this data and offer their perspective about what this revealed for NWW in practice. These critical narratives were fed back to the Department of Health during steering group meetings and in the final report.

My contribution saw service users and carers equipped with the skills and knowledge to comment on the data emerging from the evaluation. I held training sessions with service users and carers where we explored qualitative data together to develop their skills in analysis. This was followed by stakeholder events where they came together to consider the emerging findings and identify themes. This approach accorded with a shift towards research that was designed and delivered in partnership with service users and would inform policy makers and service providers how the workforce change agenda was being experienced from a service user and carer perspective. Findings from the stakeholder events conducted with service users and carers revealed that although they felt included in the research they felt far from included in NWW (Pearson et al in press). Their experience of the way professionals executed their roles depended more upon the professional's value base and commitment to collaborative

working than the changes dictated in policy guidance (Dickinson et al 2008 [14]).

One of the limitations of this research study was that it lacked a focus on the social work contribution to NWW particularly in the light of the new Mental Health Act 2007, which extended the statutory duties of Approved Social Workers to other professional groups through the creation of Approved Mental Health professionals (Bailey, 2012 chapter 3 [1]). What NWW policy did not take into account was the extent to which interdisciplinary working was evolving as result of new teams and service models. This changing context encouraged me to seek funding to undertake two related pieces of research to extend my contribution to the evidence base for NWW.

Having become acutely aware from my research with dual diagnosis services of organisations' influence on integrated working, I was interested to understand the extent to which mental health services had evolved beyond the multidisciplinary stage I define in my book (Bailey, 2012 [1]). I wanted to evaluate the extent to which there had been a move to a whole system approach that embraced services spanning primary, secondary and increasingly specialist mental health care. In order to achieve this research aim I recognised the need to employ a different conceptual approach to my evaluation framework. This led me to integrate concepts and models pertaining to systemic practice from the organisational development literature (Checkland, 1972, Benton, 2007 and Jones and Bowles 2005) into the research methods that I employed.

Funded to undertake this research I used a case study approach (Stake, 2005) in two Primary Care Trusts (PCTs), and research methods that combined a systematic review of the whole systems literature with qualitative fieldwork. Under my guidance a research assistant conducted 11 individual interviews with staff in mental health services and general practice and 8 focus groups with service users and staff teams in each of the two sites. This enabled us to understand whole systems working from the perspective of those using and delivering services. In the initial paper

from this study I explore a unique conceptual framework for understanding whole systems working in mental health, the opportunities it affords and the barriers to implementation (Bailey et al 2013 [3]).

In a related study, with a different PCT, I secured funding for a PhD studentship to explore the social work contribution to two Community Mental Health Teams that had reconfigured into four specialist teams in response to the NWW agenda. Again, using a case study approach this research replicated methods I had used previously and extended the conceptual framework for understanding integrated working (Bailey and Liyanage 2013 [7]). Using Bronfenbrenner's 1979 ecological model for systemic practice which we adapted from its original use with social work with children and young people, my PhD student set out to explore the contribution of mental health social workers to contemporary mental health services from an individual, team and organisational perspective. As supervisor for the project I guided the adaptation and application of the conceptual framework and qualitative data analysis from 24 in-depth interviews with staff. In the first paper I nested my student's findings within the wider political context of workforce and organisational change in the UK as an original paper for a special edition of the British Journal of Social Work.

This research highlighted, that despite the governments' intention to extend the Approved Social Work role to other mental health professionals with the introduction of the MHA 2007, this had not happened and all AMHPs in the four mental health teams were social workers by background. Also, that the independent nature of the social work contribution to AMHP practice was regarded as the best way to preserve service users' rights and guard against the clinical team colluding in decision-making. Of concern was the relatively disadvantaged position of mental health social workers in terms of pay and conditions compared with their nursing colleagues. This was reinforced by a perceived lack of support and feeling valued as result of the weak position of local authorities, in what social workers saw as an increasingly health dominated reconfiguration of services. The significant political implications of the research findings have been disseminated at

national conferences (Bailey, 2013) and have been used to inform the specialist inquiry into the future of mental health services in the UK (Bailey and Ryan, 2013).

Collectively, my research in the area of NWW has demonstrated that while historically service and workforce developments have moved away from the uniprofessional mental health care that characterised the asylum era, contemporary services are still far from evolving to a fully integrated, interdisciplinary model of care delivery that hinges on power sharing within and between services, professionals and service users. Describing and theorising these stages in this continuing evolutionary process is a significant contribution that I have made to understanding the journey mental health services and staff have travelled over the last 40 years. I set this out in the first chapter of (Bailey, 2012 [1]) having re-defined what delineates interdisciplinary working from other forms of collaboration. I use the remaining chapters to derive implications for practice and to offer suggestions about how individuals, teams and organisations can rise to the challenge of interdisciplinary working for the future for the whole range of mental health service users including both children and adults.

Embedding Skills for Interdisciplinary Working

As my research continued to address the question of why interdisciplinary working is delivered more effectively in some mental health settings rather than others the emerging findings have caused me to address related research questions. In particular, and stemming from my evaluation research, I realised I needed to investigate further how practitioners acquiring skills as a result of mental health training could be supported to transfer and sustain these skills in the workplace. The pivotal role of supervision was a noticeable gap in the mapping research I had conducted with Brooker and colleagues. Also as mental health services were becoming increasingly specialised in response to the Policy Implementation Guide (DH, 2001) the challenge of how to supervise staff effectively when they came from a disciplinary background different to one's own was an issue in which I was increasingly interested.

Applying my tried and tested methodological approach to an evaluation of training for supervisors (Bailey, 2003 & 2004 [20 & 19]), I found that, in contrast to the earlier work conducted by the Sainsbury Centre for Mental Health that led to the 'Pulling Together' report, practitioners needed to be competent in their unique disciplinary skills and knowledge before they could develop effective collaborative approaches to shared care interventions.

In specialist mental health services, founded on a team approach (as in Assertive Outreach) supervisors and staff needed permission to question the limitations of cross-disciplinary supervision (Bailey, 2003 & 2004) [20 & 19] and whether uniprofessional supervision was essential for effective interdisciplinary care delivery. In a small scale qualitative research study I explored these issues through the narratives of mental health managers and service users obtained in 4 focus groups (Bailey, 2012 [1]). Findings from this study, coupled with my research into training for mental health supervisors (Bailey, 2004 [19]), supported my theory that interdisciplinary working evolves from less sophisticated forms of collaborative practice. This evolutionary process I set out in Bailey, 2012 [1].

Example 3: Health Trainers in a Mental Health Setting

One way in which power is shifted from health professionals to service users is through government policies that 'encourage' the general public to take greater responsibility for their own health. The Health Trainer (HT) initiative introduced in the White Paper Choosing Health (DH, 2004) and enshrined within Healthy Lives Healthy People (DH, 2010) is an example of such a policy. HTs' introduction into the workforce was part of an overarching political strategy to prevent serious conditions such as heart disease and cancer, exacerbated by lifestyle habits including over eating, poor diet, smoking and lack of physical activity.

HTs were seen as an important resource for local communities particularly in areas of social deprivation where it was intended that through appropriate training they could better engage the public to change life style behaviours through one-to-one or group sessions. Where other

interventions were necessary, HTs could play a useful signposting role referring service users for other sources of help (Michie et al, 2008).

In 2008 I was commissioned to undertake an initial evaluation of health trainers introduced into a prison setting. I designed a case study approach incorporating the multi-level evaluation methodology I had developed and applied in previous studies (see pages). Within the first few months of the study, my research was extended to include sites in probation and in a centre run by a mental health charity. The originality of my research stemmed from the settings in which it was conducted as this was the first time the HT role had been introduced with offenders in a Category A prison and with people with severe and enduring mental illness in the community.

Drawing from the body of research that testified to the value of physical activity for improving mental health symptoms and addressing social disablement (Richardson et al, 2005, Blank et al, 2007), my research aim was to explore whether life style based interventions delivered through peer support and self-help approaches could elicit better outcomes for individuals who used the mental health centre.

I included a mix of quantitative and qualitative methods to capture the complexities and uniqueness of the HT role. Quantitative data were collected from the National Data Collection and Reporting System (DCRS) during the period of 01/04/2010 to 01/07/2011, which allowed a comparison with the client groups of HTs nationally. In addition to interviews and focus groups I included a short satisfaction questionnaire to elicit service users' reactions to the HT's intervention. This I developed collaboratively with service users for the larger project (another example of Arnstein's delegation of power) and piloted specifically with individuals in the mental health centre to check relevance of the questions to this setting.

Documentary analyses of minutes from steering group meetings with senior managers and commissioners were also undertaken to expose the strategic issues impacting on the introduction of the role into a mental health charity.

Findings from the study, which involved 72 service users, revealed an increase in the numbers of service users being referred to the Centre from outside agencies and that effective partnership working with the HT was key to this (Bailey and Kerlin, 2012 [6]). The flexibility and commitment of the HT were the two most important attributes for facilitating peer support and self-help interventions that increased service user engagement, sustained behaviour change and self-reports of improvements in mental health and wellbeing. The knowledge acquired as a result of the research was that the HT intervention embodied the meaning of recovery by creating an experience of collaboration that enabled service users to live well despite their mental illness and be in control (Fox and Ramon, 2010). The findings testified to the nature of this interdependence as pivotal for service users to be able to build on their strengths and enjoy their life. The impact of the research was the continued commissioning and expansion of the HT role within the centre by the Primary Care Trust.

B. Service User Involvement in Training and Research

Historically one of the barriers to interdisciplinary working has been the location of mental health care and treatment within the professional domain for over a century. Loxley (1997) cites the interplay between power and culture as tools with which professionals assure permanence and autonomy in their job role. Columbo et al (2002) and Fulford et al (2002) illustrate how the different value systems of respective professional groups perpetuate such power dynamics. This I argue is typical of Hickey and Kipping's level of involvement at the 'information and explanation' end of their continuum and I explore it further in the second chapter of my book on interdisciplinary working (Bailey 2012, [1]). Through my substantial and original contribution I have sought to analyse and redress this power imbalance by ensuring that the knowledge base of mental health practice and research is genuinely influenced by service users' perspectives and lived experiences and goes beyond what Arnstein (1969) would describe as tokenism (ie. the middle and less powerful level of her ladder of citizen participation).

In my book chapter on critical social work practice in mental health (Bailey, 2002 [32]) I illustrate how social work can offer an emancipatory social change orientation to mental health interventions, despite the challenge of community care policies overly concerned with public safety. Such an approach accords with the recovery model in mental health which Ramon and Williams (2005) assert requires a shift to 'a more hands on way of working characterised by the emotional closeness of the worker who demonstrates a genuine 'interest in those every day affairs which matter to the service user' (p. 15).

With the recovery movement in mental health gathering momentum, the NWW initiative offers additional opportunities for self-help interventions and peer support through the increasing number of non-professionally affiliated staff. This political shift is also supported by the wider personalisation agenda in social care generally. Within the last 5 years I have reoriented my research to embrace these changing contexts allowing me to pursue my interest in participatory methods. In this section I offer three examples of my research that uses self-help and peer support interventions as a mechanism for challenging professional assumptions about what works in mental health practice.

Example 1: Participatory Action Research with Women Offenders with Mental Health Needs

Research highlights that being female is a risk factor for mental distress with women's emotions, thoughts and behaviours more likely to be defined as madness than men's (Williams, 1984). Gender biases exist in respect of specific diagnoses, for example women are more likely to be diagnosed with borderline personality disorder, particularly associated with behaviour such as sexual promiscuity, self-harm and substance misuse (Gregoire, 2000).

Women are also more likely to have experienced domestic violence, childhood sexual abuse and sexual violence than men, such events commonly precipitating risky behaviours such as self-injury as an outward sign of inner mental distress (Itzin, 2000, Miller, et al 1995 and Yates, et al 2008).

The relationship between women's exposure to such traumatic events and self-harm has received relatively little understanding particularly for women in custody, yet Corston's report in 2007 highlighted that, although women accounted for just 5% of the overall prison population, 56% of all reported incidents of self-harm were occurring in women's prisons.

While such prevalence rates of self-harm in custodial settings have been well documented generally (e.g. Borrill, 2003, Meltzer et al (1999), Nock and Prinstein (2004) point out that the focus of such research has been limited to identifying the psychosocial constructs associated with self-harm so that screening can identify those most at risk of the behaviour and eradicate it. This approach reflects that with other mental health conditions, where the absence of relapse and the status of stability is seen as evidence of clinical recovery (Slade, 2009). Conversely the research literature testifies that those who self-harm often describe their behaviour as an attempt to cope with overwhelming distress (Cresswell, 2006), thus treatment outcomes that focus solely on the cessation of self-injury are undoubtedly over ambitious and collude with staff's and service users' unrealistic expectations of the interventions.

In their review of service user involvement the Sainsbury Centre for Mental Health (2008) concluded that the 'dearth of research literature on service user involvement in prison health research reflects its relative infancy' (p14). Where service user involvement does occur in custody this tends to exist at the informing end of Hickey and Kipping's involvement continuum through consultation with prisoner councils or through prison services such as the Listener Scheme. These approaches contrast with the emancipatory objectives of PAR which according to the literature have been absent from the prison setting (Moterro, 2000). My original research with women in prison was an overt attempt to address this gap in the research literature, to better understand the functions of self-harm for women in custody and how individual social circumstances combine within the custodial regime to influence self-injurious behaviour (Gratz, 2002). Exploring the meaning of self-injury for women in prison is the first step towards a process of growth

and adaptation to disability that Repper and Perkins (2003) describe as synonymous with recovery as a personal journey.

Leading a three-year research study funded by a PCT and the ESCR through a knowledge transfer partnership, I introduced a participatory action research approach (PAR) (Moterro, 2000, Reason, 2001), working with women and staff to address escalating prevalence rates and costs of self-injury in one UK prison. I opted for PAR as my aim was to shift the balance of power for managing women's self-injury, with women taking greater responsibility for their wellbeing in accordance with a recovery, and self-help focus (Ward and Bailey, 2013b [5]). According to Ramon (2011), PAR can assist with the process of change, particularly in large organisations where introducing a recovery orientation is likely to be received as a threat to the status quo.

My research objectives set out to influence health care for women offenders who self harmed in custody using their unique, experiential knowledge about what works (Beresford, 2000) and to offer women greater engagement with and ownership of the care they received (Ward and Bailey, 2013b [5]). This reflected the being with rather than doing to approach advocated by Hinselwood (2005), and the type of emotional closeness and hands on interventions advocated by Ramon and Williams (2005).

From my earlier research with service users I wanted to ensure that PAR would capitalise on the secondary gains for women, prone to entrenched stigma and social exclusion, through the increased self-esteem and social benefits involvement in the research could afford (Blakemoore, 2003). However Mason and Boutilier (1996) highlight the dilemmas and complications of sharing power in participatory research which my experience had taught me would be highlighted in the prison system. Given the sensitive subject matter I decided it was too great a risk and that women would be set up to fail, by being trained as researchers as in my previous research. Rather, through the cyclical process of PAR (planning, action and critical reflection) I would aim to involve women and staff in

other ways, such as in the design and delivery of the research tools and the associated training and self-help materials (Ward and Bailey, 2011 [12]).

During the planning stage of this study, my research objective was to transfer the knowledge base regarding effective interventions for self-injury into the prison setting and to explore how women and staff could gain a better understanding of the trigger points for self-harm in order to intervene more effectively. With my Research Associate I used focus groups and the technique of process mapping to understand women's journeys through the prison and the interventions they had found helpful or believed would make a difference in the future. These experiences influenced the design of questionnaires and interviews used later in the study.

Also in the planning stage my Research Associate gathered self-help materials that were already available from service user groups to support a recovery oriented approach, generally (for example Copeland, 1997) and specifically in relation to self harm (Pembroke, 1994, www.harm-ed.co.uk). We shared these materials with women in a series of group discussions that led in the action stage, to materials being adapted and included in self-care support packs that were then piloted before being made available to women in the prison generally. The packs included art work and note books that the women had produced during education sessions in the prison. Additional materials included distraction activities and a self care plan based on Copeland's Wellness and Recovery Action Plan (WRAP) that women had revised and shortened to help them talk about their self-harm with prison staff. In addition, women worked together to produce case studies and additional art work that formed the basis of self-harm awareness raising that were co-delivered in the action stage by the women and the Research Associate to over 150 prison staff.

Critical reflection regarding the impact of this knowledge transfer within the prison was evidenced by women's experiences captured through 50 completed questionnaires and 15 individual interviews, together with questionnaires completed by staff about their experiences of dealing with women's self-injury in custody and their qualitative feedback having

attended the awareness raising sessions co-delivered by the research associate and women who had participated in the study. This reaction level evaluation revealed that staff rated the awareness raising sessions as overwhelmingly positive (Ward et al 2012 [30]).

Women's narratives collected from the questionnaires and interviews testified to a culture shift in the prison which enabled them to feel more able to share their concerns relating to self-injury taking a more proactive approach to managing their behaviour (Ward and Bailey, 2013b [5]).

Materials to support self-help and peer support interventions for women who self-injure have been disseminated to safer custody leads in women's prisons, to the National Offender Management Service (NOMS) Safer Custody Lead and at national and international conferences and workshops. These materials are informing NOMS national resource pack to support prisoners who self-harm in custody. They are also being used together with the PAR approach in a current study where I am seeking to improve primary care interventions for young people who self-harm.

Having learned valuable lessons about the ethical challenge of conducting research using anti-oppressive methods such as PAR I have become even more committed to enhancing the involvement of service users in research. In contrast to Crighton (2006) who cautions that much of the research carried out in custodial settings does not benefit prisoners as the researched population my research with women in custody was able to demonstrate a culture shift within the prison that led me full circle to revisit the debate about how to implement effective mental health interventions with offenders in settings that are custodial and coercive (Moser et al 2004, Towl, 2004).

Being mindful of Gill's work in 2009 which testifies to the more complex ethical dilemmas of involvement in custodial settings leading to research being cancelled often before it begins, my Research Assistant and I wanted to highlight how we had tackled the ethical issues that we encountered in using PAR successfully. Our journey through the ethics of the PAR process

we have discussed in Ward and Bailey (2012 [9]), a paper which has attracted significant attention subsequently from others attempting research within the prison system.

The findings of the PAR study with women offenders has provided further support for the link drawn in the self-harm literature generally between the behaviour and previous experiences of trauma such as abuse (Ringel and Brandell, 2011, Tantum and Hubbard, 2009, Simpson, 2004). However where previous research has focused on trying to demonstrate which treatments are most effective in dealing with the behaviour, clinicians have failed to reach definitive conclusions (Hawton, 1999).

Using the systematic review methodology I had tried and tested previously in my research relating to interdisciplinary training and working in mental health (Bailey et al 2013 [3] & Bailey, 2002a [21]) I enlisted the assistance of two research associates to replicate the method with the aim to document what contributions service users have made to the evaluation of psychosocial interventions for self-harm, what methods of involvement have been employed and the ways in which such involvement could supplement empirical evidence for effective interventions. Whilst the systematic review method did not involve service users per se the emphasis was placed upon the methods by which they had been involved in the body of research for effective interventions in western cultures (Ward et al, 2012 [10]).

Findings from the systematic review testified that new ways of thinking need to be developed about interventions that seek to eradicate self-injury as these may be inappropriate where individuals use self-harm as a coping strategy. Punitive interventions are also out of sync with more harm-prevention methods used in other mental health services for example with people who use substances. Of the 65 studies included in the systematic review the most compelling evidence for positive change was gleaned from 5 studies that explored non-coercive, non-judgemental and empowering relationships either between service users who self-harmed (peer support) or with the professionals working with them. Findings also testified to the importance of using research methods such as interviews or other forms of

participation to guard against the high attrition rates evident in the more empirically based studies. Overall the review lends support for my growing, original and substantive contribution to research methods that build reciprocal relationships with service users that aim to involve, empower and promote anti-oppressive practice.

Example 2 : Service User Involvement in the Assessment of Training

Whilst much of my early research focused upon mental health education and training that I had designed and delivered collaboratively with service users I recognised that such an approach only went part way along Hickey and Kipping's involvement continuum in addressing the power imbalance between practitioners who delivered mental health services and those who used them (Bailey, 2012 [1]). Whilst there was some limited social work literature on the involvement of service users in assessing social work students' practice (Baird, 1990, Shennan, 1998) this had not happened in mental health education and training more generally, where typically the decision making process remained with clinicians.

One of the criticisms that has beset service user involvement in the design and delivery of mental health training and services is that the individuals who get involved are often unrepresentative of the service user body as a whole (Bailey, 1997 & 1998 [27 & 26]). I have tackled this in my research by employing a snowball sampling strategy, as part of an overarching action research approach (Bailey, 2005, [18]). Such an approach allows the researcher to capitalise on the service user groups and networks to which they have access and to involve service users in decisions about the sampling strategy. I used such a strategy to bring together more than 20 service users across the West Midlands region to collaborate in designing the assessment criteria for a module on Service User Participation and Self-Help on the MA in Community Mental Health at Birmingham University. According to Perkins and Repper (1998) an indication that service user involvement is progressing towards empowerment is when service users are involved in key decisions, rather than limited to those where outcomes are considered trivial.

Having recruited and involved the service users in developing the assessment criteria, I then offered them training sessions in giving written feedback to students that illustrated their perspective, derived from their lived experience, on the materials students had submitted to demonstrate evidence of working in partnership. This was important as Ramon (2011) illustrates how service users' wish list for recovery-oriented services differs from that of providers who, despite respecting service users, often stress partnership without power and at times slip into 'doing for' interventions. By involving service users in giving feedback I wanted to ensure that their knowledge and expertise influenced practitioners' attempts to work in partnership through the assessment process.

As I facilitated the training and support sessions with service users (the latter at their request), for the duration of the MA from 1997-2005, I learned valuable lessons about what service users valued about involvement. Advantages included the beneficial effects of the social networks that service users developed and found intrinsically fulfilling, as well as being engaged in meaningful activities that they believed would make a difference. Of importance to service users was having a menu of ways in which they could participate which reflected their different skills, experience and confidence. These lessons I have applied in my subsequent research (see below) and summarised in (Bailey, 2012 [1]).

Example 3: Service User Involvement in the Evaluation of Services

The new labour movement of the 1990s set the policy agenda for increased public and patient involvement (PPI) in health care generally (DH, 2005b and 2006), importantly linking it with key performance indicators of quality (DH, 2008b). In response to the political agenda many Trusts ensured the public were represented on their partnership boards and employed staff to undertake PPI data collection. One example of a PPI initiative within a mental health Trust was a service user representative scheme that had been evaluated by one of my social work students (Haswell and Bailey 2007, [17]). This evaluation had provided some support for how meaningful involvement could be achieved and its potential for informing care delivery.

Committed to continuing the involvement agenda the mental health Trust concerned commissioned me to undertake a further piece of research as a follow up to the original study, that would gather detailed information about service users' satisfaction with the care provided by the rehabilitation wards. Having persuaded the funders that an action research approach was called for in order to promote a service user-led evaluation, I facilitated the planning stage of PAR which included setting up of a project steering group, Chaired by one of the service user representatives.

This group commandeered the recruitment of the Research Associate whose remit was to train service user researchers in methods of data collection and analysis. Maddock et al, (2004) and Faulkner and Thomas, (2002) contend that inclusive service user led research focuses just as much on the process of undertaking the research in the first instance as on the outcomes from it. This accorded with the secondary aim of the study which was to identify the barriers to and support for service user led research to be conducted effectively within the Trust as a large, complex organisations.

Despite what I considered to be a robust PAR design National Health Service ethical approval processes created complications for the project from the outset. This was because the PAR approach hinged upon the data collection tools being designed in collaboration with the service user researchers who could not be recruited until ethical approval was obtained. This administrative impasse was explored in more detail as the research project eventually got underway. In retrospect, the research contribution was achieved through the realisation of the secondary aim of the study as the barriers and support systems for service user led research were investigated in more depth than I had originally intended. To achieve this I designed in-depth, semi-structured interviews based on a literature review of service user involvement in mental health research, undertook documentary analysis of the project steering group meeting minutes and thematically analysed issues that arose during the first phase of the project including the feedback obtained from the ethical approval process.

The findings from the study testified to the value of service user led research but the hurdles that needed to be overcome to undertake it. These were presented as a series of dos and don'ts through a range of dissemination events. Pursuing the debate about the barriers to service user led research in my role as national social care lead for the Mental Health Research Network in England I was able to offer support to the national organisation INVOLVE in a challenge to NHS ethics.

By the time my research using participatory methods commenced with offenders in 2008, INVOLVE had secured the agreement from the National Institute for Health Research (NIHR) that service user involvement in the planning of mental health research could go ahead in advance of ethical approval. This development has marked a significant milestone for the recognition of service user involvement in mental health research nationally. My role as the National Social Care Lead for the Mental Health Research Network allowed me to support colleagues from INVOLVE to secure this step-change in the involvement of service users in mental health research.

PART THREE: Next Steps

Over the past 20 years my substantial and original contribution has influenced training and evaluation within the mental health workforce to redefine what is understood by interdisciplinary working and learning and the centrality of power giving and sharing in order for service users to be meaningfully involved in training and research.

The exciting thing about my journey in researching mental health to transform education and practice is that it was to some extent unplanned and has therefore taken me to interesting places and through life changing experiences such that my final destination I could never have conceived of at the outset.

My original and substantial contribution has led me to combine my background in anti-oppressive practice as a social worker and researcher with my knowledge of mental health issues and interventions. My

contribution has tackled the issue of power and importantly how when it is given away it allows for the evolution of a redefined interdisciplinary approach synonymous with recovery and a shared responsibility between professionals and service users for delivering effective mental health care.

I am therefore committed to furthering the use of participatory methods in the research I am currently undertaking with young people with substance misuse issues and with young people requiring safeguarding interventions.

Using the PAR methodology I am leading an oral history project which will see service users in two regions of the UK sharing their experiences of the asylums including the elements of care that they consider have been lost as well as what has been gained through the deinstitutionalisation of mental health services.

In addition my interest in the link between trauma and mental health issues in adulthood is taking me into the territory of genealogy working with colleagues to explore the experiences of those with dementia and the key role attachment may play in understanding how some individuals may be more vulnerable to cognitive impairment in later life than others.

In all of the above my commitment to research methods that embody anti-oppressive practice and redefine relationships with service users is demonstrated along with my aim to shift service user research closer towards the emancipation end of Hickey and Kipping's continuum. It is this endeavour along with my continued curiosity to understand what works in mental health care that retains my passion as an academic and for which I hope to be recognised through the remainder of my career.

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Appendix 1 Published Work on Which the Submission is Based by Themes

Full Reference	Researching and Theorising Training and Evaluation within the Mental Health Workforce	Service User Involvement in Training and Research
Books		
1 Bailey, D. (2012) Interdisciplinary Working in Mental Health. London, Palgrave Macmillan		
Books: Edited Works		
2 Bailey, D. (Ed.) (2000) At the Core of Mental Health Practice: Key Issues for Practitioners, Managers and Mental Health Trainers, Brighton, Pavilion Publishing		
Articles: Refereed Journals in Press (Submitted and Accepted)		
3 Bailey, D. Casey, B. Paxton, R. and Linde, K. (2013) Understanding the Whole Mental Health System: identifying a conceptual framework, Journal of Interprofessional Care, Vol and page numbers to be confirmed		
4 Ward, J. and Bailey, D. (2013a) The Utility and Functions of Self-harm for Women in Prison: Implications for Clinical Practice. International Journal of Forensic Mental Health, Vol and page numbers to be confirmed		
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7 Bailey, D. and Liyanage, L. (2012) The Role of the Mental Health Social Worker: Political Pawns in the Reconfiguration of Adult Health and Social Care, British Journal of Social Work, vol 42(6) 1113-1131		
8 De Motte, C. and Bailey, D. (2012) How does prison visiting affect female offenders mental health? Implications for Education and Development, Journal of Mental Health Training Education and Practice, vol. 7(4) 170-179		
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15 Bailey, D. (2007a) Training graduate primary care mental health workers for collaborative practice: part 1. The Journal of Mental Health Training, Education and Practice 2 (3) 12-22.		
16 Bailey, D. (2007b) Evaluating training for collaborative practice for graduate primary care mental health workers. The Journal of Mental Health Training, Education and Practice 2 (4) 19-29.		
17 Haswell, S. and Bailey D. (2007) What is the role of a hospital Service User's Representative Scheme for Promoting Service User Involvement in Mental Health Care Delivery?, Journal of Mental Health Workforce Development, Vol, 2 (1) pp.12-22		
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19 Bailey, D. (2004) The Contribution of Work-based Supervision to Interprofessional Learning on a Masters programme in Community Mental Health, Active Learning in Higher Education, Vol 5(3) pp. 263-278		
20 Bailey, D. (2003) The Contribution of Work based Supervision to Interprofessional Learning on a Masters Programme in Community Mental Health, Journal of Interprofessional Care, Vol 14, No 3 pp. 306-07		
21 Bailey D. (2002a) Training Together: An Exploration of a Shared Learning Approach to Dual Diagnosis Training for Specialist Drugs Workers and ASWs Social Work Education Vol. 21, No. 5. pp. 565-581		
22 Bailey, D. (2002b) Training Together Part Two: An Exploration of the Evaluation of a Shared Learning Programme on Dual Diagnosis for Specialist Drugs Workers and ASWs. Social Work Education Vol. 21 No. 6. pp. 685-699		
23 Brooker, C., Gournay, K., O'Halloran, P., Bailey, D. & Saul, C. (2002) Mapping Training to Support the Implementation of the National Service Framework for Mental Health. Journal of Mental Health, 11, 1, 103-116.		

Full Reference	Researching and Theorising Training and Evaluation within the Mental Health Workforce	Service User Involvement in Training and Research
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Appendix 2: List of Publications

Books:

Bailey, D. (2012) *Interdisciplinary Working in Mental Health*. London, Palgrave Macmillan

Books: Edited Works

Bailey, D. (Ed.) (2000) *At the Core of Mental Health Practice: Key Issues for Practitioners, Managers and Mental Health Trainers*, Brighton, Pavilion Publishing

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